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Notice of Independent Review Decision

DATE OF REVIEW: March 9, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Redo left L4 partial hemilaminectomy with left L4/L5 partial medial fasciectomy, left L4 discectomy with nerve root decompression. 2 inpatient days

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Diplomat, American Board of Orthopaedic Surgery
Fellowship trained in spine surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Overturned (Disagree)

Medical documentation **supports** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office Visits (05/26/09 – 01/21/10)
- Operative notes (08/07/09)
- Diagnostics (01/05/10)
- Utilization Reviews (01/14/10, 01/27/10)

Dr.
- Office visits (08/21/09 – 02/04/10)
- Operative notes (08/07/09)
- Diagnostics (01/05/10)
- Utilization Reviews (01/27/10)

Orthopedic Associates
Office visits (08/21/09 – 02/04/10)
- Operative notes (08/07/09)
- Diagnostics (01/05/10)
- Utilization Reviews (01/27/10)

TDI
- Utilization Reviews (01/14/10, 01/27/10)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who suffered a work-related injury to his lumbar spine on xx/xx/xx. He developed pain in the left side of his back and in the left lower extremity.

2008: No records are available.

2009: M.D., evaluated the patient for persistent left lower extremity neuropathic pain, foot heaviness and episode of giving way of the knee twice while walking. The following treatment history was noted: *Dr. initially evaluated the patient and subsequently referred him to Dr. for a neurosurgical evaluation. Magnetic resonance imaging (MRI) of the lumbar spine in April 2008 showed left-sided posterolateral disc protrusion at L4 producing narrowing of its left lateral recess and left neural foramina. Surgical history was significant for left-sided L5 hemilaminectomy and discectomy in 1980, cervical spine fusion in 1997 and left nephrectomy. Medical history was positive for depression, hypertension and chronic lower back pain. The patient was treated with an epidural steroid injection (ESI), physical therapy (PT) and opiate pain relievers including triplicate prescription pain relievers, but without much relief.* Examination revealed diminished sensation in the left lateral thigh along the dorsum of the left leg into the dorsum of the foot, left foot dorsiflexion 4/5, left great toe and lesser great toe extensors 4/5 and quadriceps 4/5. There was mildly positive sciatic tension especially with internal rotation. Dr. diagnosed L4 herniated disc with L4 stenosis and progressive left lower extremity L5 sensorimotor radiculopathy with sciatica.

On August 7, 2009, Dr. performed left L4 partial hemilaminectomy with left L4-L5 partial medial facetectomy, left L4 annulotomy, discectomy and nerve root decompression.

Postoperatively, the patient continued to complain of pain into his back radiating down the left lower extremity. He complained of pain to the right leg as well. Dr. noted tightness in the hamstrings with mild leg pain and positive seated straight leg raise (SLR) test. He diagnosed postoperative lumbar radiculitis, prescribed Medrol Dosepak and Neurontin, refilled Oxycodone and Mobic, recommended continuing wearing back support and off work status and initiated postoperative rehabilitation including aquatic therapy. The patient continued to complain of back pain and leg pain, right treater than left. Dr. noted residual foot and ankle weakness, mildly positive SLR and lateral sensory deficit of the leg. X-rays of the lumbar spine were negative for radiographic instability. Dr. ordered lumbar MRI with enhancement.

2010: On January 5, 2010, MRI showed: (1) Status post right hemilaminectomy at L5-S1 with postcontrast enhancing granulation tissue encasing the right descending S1 nerve root. (2) Status post left hemilaminectomy at L4-L5 with disc desiccation, mild-to-moderate loss of disc height, retrolisthesis, enhancing granulation tissue and possible left paracentral extrusion within the operative tract effacing the left thecal sac and left descending L5 nerve root resulting in mild left foraminal stenosis. (3) Disc desiccation with mild-to-moderate loss of disc height at L1-L2 associated with retrolisthesis and shallow central disc protrusion abutting the thecal sac. (4) Disc desiccation at L2-L3. (5) Shallow broad-based disc displacement at L3-L4.

On January 8, 2010, Dr. noted the patient had undergone supervised PT. He had pain to the right side of his back radiating down the right leg requiring continuation of supportive medication. The updated MRI showed a recurrent extruded disc to the left at L4 causing severe spinal stenosis. Dr. assessed left L4 recurrent extruded disc herniation with left lower extremity sciatica and radiculopathy and recommended surgical intervention consisting of a redo left L4 partial hemilaminectomy, left L4-L5 partial medial facetectomy, left L5 discectomy and nerve root decompression.

On January 14, 2010, D.O., denied the request for redo surgery with the following rationale: "*As per medical records, the patient complains of back pain that shoots down his right leg. He had some foot and ankle weakness on the left with SLR being positive and some sensory deficit laterally in the left leg. Clinical records indicated that the patient has been treated conservatively with oral medications and PT. However, there was no evidence provided that this patient had stretching or strengthening exercises or had maximized the effect of oral medications. There was no PT progress notes attached indicating non-improvement. Pain medications given were not included for review. Medical necessity of the requested procedures has not been fully established. Additional relevant information from a peer-to-peer contact is needed to substantiate the medical necessity of this request.*"

On January 21, 2010, Dr. in a correspondence letter stated that the patient had consistent left-sided complaints the entire time although he also had some right-sided complaints, which were not likely related to the L4 segment, but rather remotely operated upon L5 segment. The left lower extremity sciatic pain and radiculopathy necessitated a postoperative MRI and which findings strongly correlated with the patient's radiculopathy and sciatic tension in the left lower extremity. The patient had had a course of supervised PT of 10 visits including aquatic therapy. A structural study showed a large recurrent disc herniation at L4 to the left which correlated with the patient's clinical complaints of persistent left lower extremity sciatica and left lower extremity clinical weakness as well as clinically evident sensory radiculopathy. It also involved the L5 root distribution, which correlated with L4 recurrent disc herniation. Dr. stated all of the rationale indicated by the neurosurgeon pertained to patients who had virgin backs and had never undergone operative intervention. There was no data provided through the Official Disability Guidelines (ODG) with regards to the indications for a redo laminectomy and discectomy.

On January 27, 2010, M.D., denied the appeal for surgery with the following rationale: "*The request for a repeat left L4 discectomy and nerve root decompression is not recommended as medically necessary. This is an appeal of a prior denial in which the previous reviewer's opinion is not available for review. The patient has continuing complaints postoperatively of radiating left leg; however, there is inconsistency on whether the right or left leg is most symptomatic. A clinic note on September 22, 2009, states the patient is beginning to demonstrate right lower extremity pain and clinic note on December 15, 2009, states the patient has right greater than left lower extremity pain. It is noted that Dr. opines that the patient has had consistent left lower extremity pain; however, the patient's subjective complaints differ in the clinical documentation. The MRI study does not demonstrate clear evidence of a recurrent disc herniation and no recent physical exams were submitted for review demonstrating any evidence of focal neurologic deficits consistent with nerve root or cord impingement. Additional information would be required in order to determine medical necessity and at this time the surgery is not indicated.*"

On February 4, 2010, in an addendum the correspondence dated January 21, 2010, Dr. stated that the patient had a remote history of prior right-sided L5 laminectomy and had some issues from time to time concerning right-sided back and leg discomfort, which had nothing to do with his xx/xx/xx injury for which he was being treated and the fact that the patient's postoperative course documented persistent neuropathic pain and increasing radiculopathy in the left leg and the amended postoperative lumbar spine MRI clearly showed a uncovertebral large extruded recurrent disc herniation at L4. There was no reason to further delay authorization for medical necessary surgery. He stated the basis for non denial was primarily due to the fact that the radiologist report was not clearcut herniation. The amended report shows that the radiologist agreed that there was an extremely large recurrent disc herniation at L4. Dr. stated the patient had a legitimate problem with clinically evident and increasingly intractable radiculopathy and

left leg sciatica correlating with his postoperative MRI scan and recommended proceeding with an IRO.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

I have had the opportunity to review the following records on IRO case # 25728. These records are listed on the summarization by Oristech (MATUTECH). I will not re-summarize the records as I find the summarization to be consistent.

Review outcome overturned:

The basis of this opinion is as follows: Mr. had a work injury on xx/xx/xx which resulted in radiculopathy to the left lower extremity. The patient had a subsequent MRI, which showed an L4-L5 disc herniation with L4-L5 stenosis. The patient had approval given for the operative intervention and this was completed on August 7, 2009. There were no noted postoperative complications.

The patient subsequently had recurrent symptoms and findings into the left lower extremity. He was also reported to have some symptoms into the right lower extremity. Due to these ongoing symptoms, the patient had MRI performed with and without contrast on January 5, 2010, and read by Dr..

Dr. issued a report and amended report on January 28, 2010. Dr. writes “The patient apparently has a left-sided radiculopathy with radicular pain in the L5 distribution and neurological deficits. Large L4-L5 left recurrent disc extrusion correlates with his clinical presentation may be presumed to be the cause of the left-sided radiculopathy.”

There are also further records from Dr. office regarding the patient’s clinical symptoms and findings as well as the MRI interpretations.

Given the correlation of the imaging and the amended report from the radiologist and the clinical course of Mr. , the proposed repeat surgery at L4-L5 on the left would appear to be consistent with clinical practice of orthopedics spine surgery as well as evidence-based medicine including ODG criteria. Thus the previous denials for surgical intervention at L4-L5 with two-day inpatient stay are overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES